

STATE OF NEVADA  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH DIVISION  
BUREAU OF HEALTH CARE QUALITY AND COMPLIANCE

**PERMIT APPLICATION**

(THIS APPLICATION MUST BE TYPED OR FILLED OUT LEGIBLY IN INK)

☐ INITIAL PERMIT    ☐ CHANGE OF NAME FOR THE PERMITTED ENTITY

☐ CHANGE OF OWNERSHIP (indicate date of the change of ownership): \_\_\_\_\_

A change of ownership application must be filed immediately in accordance with R179-09 sec. 9

Change of ownership applications must be complete no more than 45 days after the change occurs.

THE ENTITY'S D.B.A. NAME \_\_\_\_\_  
(D.B.A. = Doing Business As)

STREET ADDRESS \_\_\_\_\_  
(Physical location of the entity's operation)

CITY \_\_\_\_\_ COUNTY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE \_\_\_\_\_ FAX \_\_\_\_\_

THE ENTITY'S MAILING ADDRESS \_\_\_\_\_  
(If different from above)

CITY \_\_\_\_\_ COUNTY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

OWNER OF THE ENTITY (Applicant/Licensee) \_\_\_\_\_

If owner is a natural person, IS THE OWNER 21 YEARS OR OLDER? ☐ YES ☐ NO (R179-09 sec. 9)

ADDRESS \_\_\_\_\_  
(If owner is a corporation, give corporate office address, otherwise indicate owner's address)

CITY \_\_\_\_\_ COUNTY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE \_\_\_\_\_ FAX \_\_\_\_\_

FOR ALL PARTNERSHIPS AND CORPORATIONS: LIST EACH OFFICER AND DIRECTOR AND  
PERSON HAVING A DIRECT OR INDIRECT OWNERSHIP INTEREST IN THE ENTITY OF 10%  
OR MORE:

\_\_\_\_\_  
\_\_\_\_\_

NAME OF PERSON IN CHARGE OF THE FACILITY

\_\_\_\_\_

NAME OF ACCREDITING ORGANIZATION

\_\_\_\_\_

**OWNER OF REAL PROPERTY** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

**CITY** \_\_\_\_\_ **COUNTY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_

**PHONE** \_\_\_\_\_ **FAX** \_\_\_\_\_

Nevada Revised Statute 449.442 requires a permit before offering services of sedation or general anesthesia to a patient. LCB File No. R179-09 authorize non-refundable fees (See Attached Fee Schedule). An application is valid for one year after the date on which the application is submitted. The application must be typed or filled out in ink. The application will not be considered complete until all required attachments are received. See the attached instruction sheet for the required attachments.

Return your completed application to an office of the:

**HEALTH DIVISION**

**BUREAU OF HEALTH CARE QUALITY AND COMPLIANCE**

1550 E. College Pkwy. Ste. 158, Carson City, Nevada 89706

I HAVE READ THE FOREGOING QUESTIONS AND ANSWERED EACH AS INDICATED. THE ANSWERS ARE TRUE AND A COMPLETE REPRESENTATION TO THE BEST OF MY KNOWLEDGE. I HAVE READ, UNDERSTAND AND AGREE TO COMPLY WITH THE RULES AND REGULATIONS PERTAINING TO THE SPECIFIC STATUTORY TYPE OF ENTITY FOR WHICH THIS APPLICATION IS HEREIN MADE. I AUTHORIZE RELEASE OF SUCH INFORMATION AS MAY PERTAIN TO THE PURPOSE OF THIS APPLICATION.

**SIGNATURE OF REPRESENTATIVE OR OWNER** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PRINTED NAME OF REPRESENTATIVE OR OWNER** \_\_\_\_\_

**TITLE OF PERSON SIGNING APPLICATION** \_\_\_\_\_

**SUBSCRIBED AND SWORN BEFORE ME THIS** \_\_\_\_\_ **DAY OF** \_\_\_\_\_ **20** \_\_\_\_\_

**NOTARY PUBLIC SIGNATURE** \_\_\_\_\_ **IN AND FOR THE**

**COUNTY OF** \_\_\_\_\_, **STATE OF NEVADA.**